STATE OF HAWAII
DEPARTMENT OF HEALTH
4348 Waialae Avenue, #648
Honolulu, Hawaii 96816

APPLICATION #_____

Medical Use of Marijuana Grow Site Certification

SECTION E. *This section to be signed by the Applicant AND Caregiver, if designated.*

Applicant's Name: _____
Last First Middle

Caregiver's Name: _____
Last First Middle

Mark One

□ Applicant/Qualifying Patient will grow own medical marijuana
□ Primary Caregiver will grow medical marijuana for Applicant/Qualifying Patient
□ Neither Applicant/Qualifying Patient nor Primary Caregiver will grow medical marijuana
(YOU MUST MARK THIS IF YOU ARE NOT PLANNING TO GROW MEDICAL MARIJUANA)

If applicant/qualifying patient or caregiver are designated above to grow, indicate the LOCATION where the medical marijuana will be grown:

□ Applicant/Qualifying Patient's Residence Address (as noted on this application) _____ Qualifying Patient Initials

□ Primary Caregiver's Residence Address (as noted on this application) _____ Caregiver Initials

□ Other Address as follows: (must be owned or controlled by either the applicant or caregiver)

_____ HI _____
Street (include apt#) City State Zip Code

If no street address, TMK (and Description, REQUIRED): _____

Person who owns or controls the "Other Address" property: □ Applicant _____ initials □ Primary Caregiver _____ initials

Form CBD-001gsc
Revised 11/24/14

APPLICANT'S STATEMENT OF UNDERSTANDING AND CERTIFICATION
(must be signed by applicant/qualifying patient, regardless of intent to grow)

I, the **applicant**/qualifying patient, CERTIFY that :

□ **Yes** 1. I plan to grow (or NOT grow) my medical marijuana, as indicated above.

□ **No** 2. If I've indicated a grow site location other than my residence AND I've indicated that I either own or control the "Other Address", as evidenced by my initials above, I attest **that I either own or control the stated grow site location**.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document I acknowledge that I am subject to part IX, chapter 329, HRS, and all other applicable laws for the medical use of marijuana in the State of Hawaii. I understand that even though I am following Hawaii state laws regarding the medical use of marijuana, I may not be protected against arrest, prosecution, or conviction under Federal law.

APPLICANT'S SIGNATURE Date

CAREGIVER'S STATEMENT OF UNDERSTANDING AND CERTIFICATION *(must be signed by primary caregiver IF designated to grow **or** IF primary caregiver either owns or controls the grow site location)*

I, the primary **caregiver**, CERTIFY that :

1. I understand and acknowledge that *(MARK ONE)*
   □ I have been designated to grow medical marijuana by the aforementioned qualifying patient, OR

□ **Yes** □ The qualifying patient will grow on a site that I own or control; AND

□ **No** **2.** If I've indicated a grow site location other than my residence AND I've indicated that I either own or control the "Other Address", as evidenced by my initials above, I ATTEST **that I either own or control the stated grow site location**.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document I acknowledge that I am subject to part IX, chapter 329, HRS, and all other applicable laws for the medical use of marijuana in the State of Hawaii. I understand that even though I am following Hawaii state laws regarding the medical use of marijuana, I may not be protected against arrest, prosecution, or conviction under Federal law.

PRIMARY CAREGIVER'S SIGNATURE Date